

Creating a Culture for Interdisciplinary Collaborative Professional Practice

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Abstract: The future of the health system is dependent on health professionals re-tooling the way we practice together. No longer can a multi-disciplinary model support the complex health needs of many clients nor can any one-health profession have all the knowledge needed to provide total patient-centred care. However, our current education and health systems are structured around a multi-disciplinary model of practice with physicians or nurse practitioners as decision-makers and rarely are clients included in care planning. True interdisciplinary practice is defined as a *partnership between a team of health professionals and a client in a participatory, collaborative and coordinated approach to shared decision-making around health issues*, requires a revamping of how future health professionals are educated and how the system can accommodate shared decision-making. A client-centered collaborative professional practice model is proposed in this paper as a means for fostering and facilitating the culture for this change.

Key words: interdisciplinary practice, collaboration, client-centered, culture, change

In 2002 Romanow challenged us to move towards “teamwork and interdisciplinary collaboration... from health care providers either working in primary health care organizations or participating in networks of providers.”¹⁻¹¹⁷ This raises the recommendation for teamwork to transform the traditional multidisciplinary approach to health care delivery in favour of a more interdisciplinary* approach that recognizes and values the expertise and perspectives of a variety of different health care providers. Interdisciplinary care enables “a partnership between a team of health professionals and a client in a participatory, collaborative and coordinated approach to share decision-making around health issues.”² Mov-

ing towards patient-centered interdisciplinary collaborative practice (IDCP) requires a fundamental shift in health professionals’ attitudes towards such an approach. A change to IDCP requires alterations in existing health professionals’ values, socialization patterns, and workplace organizational structures. In order to facilitate such a change there is a need to create a new culture in health systems that supports trust, a willingness to share in patient care decision-making, and meaningful inclusion of patients and/or family members in discussions about their care.

There has been extensive research around teamwork, team operations, and team roles but a paucity of research around the processes teams must go through as they form and develop collaborative practice approaches. We argue that development of a culture supporting collaborative practice is a critical step forward. The need for a conceptual model for IDCP will be addressed in this paper. Consequently we are proposing a conceptual framework to guide the development of IDCP teams.

*Medicine makes the distinction between *intraprofessional* and *interprofessional* teams and argues that within the discipline there are a number of specialties and therefore to address cross-professional work the latter term should be adopted. However, we argue if a primary health care client-centered approach is advocated then the term interprofessional may create a perception of exclusivity by clients at the very time when health teams are attempting to enhance inclusively. Drinka & Clarke (2000) stated “we considered using the term interprofessional, but realized early on that this term is limiting in the sense that the team might consist of more than just professionals...” xvi

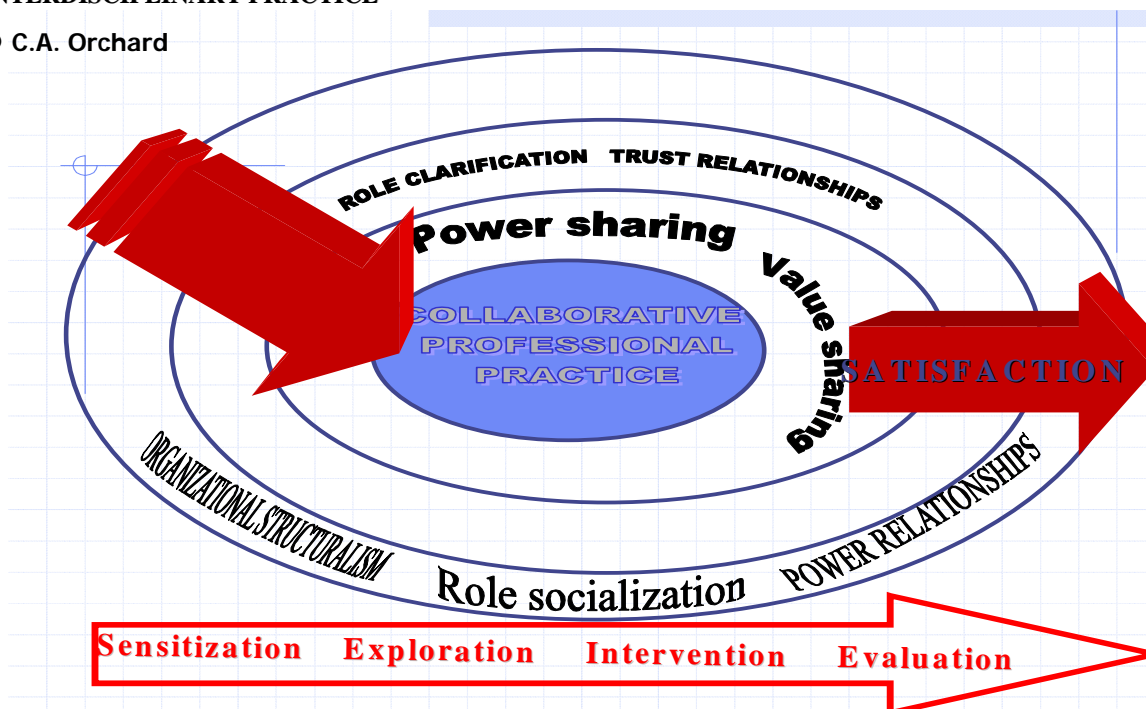
Conceptual Framework

The conceptual framework is composed of four concentric ovals (Figure 1) with the innermost being the goal of patient-centered interdisciplinary collaborative practice. The outermost oval contains barriers to goal achievement. These being: *organization structuralism*^{3,4,5,6,7,8,9}, *power relationships* between health care professionals^{10,11,12,13} and between health care professionals and their clients¹⁴ and *role socialization* into health disciplines⁴ and society's expectations of sickness roles.¹⁵ These

and patients.¹⁷ The power imbalance between health professionals due to professional socialization patterns also leads to a lack of sharing in decision making around patients.¹⁸ Furthermore, the power imbalance within the health care system and between the health care system and the patient¹⁹⁻²¹ frequently excludes the patient from the planning for, implementation of, and evaluation of their health care.²² This leads to frustration amongst all parties who are not part of the decision making process.^{23,24} As an outcome, tests can be delayed, inappropriate medications or treatments may be ordered and adminis-

Figure 1 CONCEPTUAL MODEL FOR PATIENT-CENTERED COLLABORATIVE INTERDISCIPLINARY PRACTICE

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three variables are seen as creating **barriers** to collaborative patient-centered care. For purposes of this discussion *organizational structuralism* is defined as the administrative organization and decision making processes adopted within institutions; *power imbalances* as the ability to exert pressure on another by virtue of formal or informal positions; and *role socialization* being development of behaviors, and attitudes deemed necessary to fit into a cultural group.

These barriers are perceived to create a sense of powerlessness among some health professionals¹⁶

tered, treatment appointments may be missed, and patients may feel frustrated that their needs are not heard. This would conflict with health care professionals' social accountability[†] for the care they provide.

[†] Social accountability is defined as "the obligation to answer for a responsibility conferred, [that] is increasingly recognized as a key component in the health care system"²⁵⁻³⁹¹

Transforming barriers into enablers is accomplished through a change process using four phases of change: *sensitization*, *exploration*, *intervention*, and *evaluation* (Figure 2). These phases create the environment for an interdisciplinary practice culture. Enablers include: *role clarification* which is gaining an understanding of both the roles assumed

During the *sensitization phase* of the change process *power imbalances* and *varying values* are challenged²⁴. Professionals explore the meaning of both their roles and decision-making processes thus creating an awareness of their current practice constructs. Throughout the *exploration phase* health professionals explore their roles and seek clarifica-

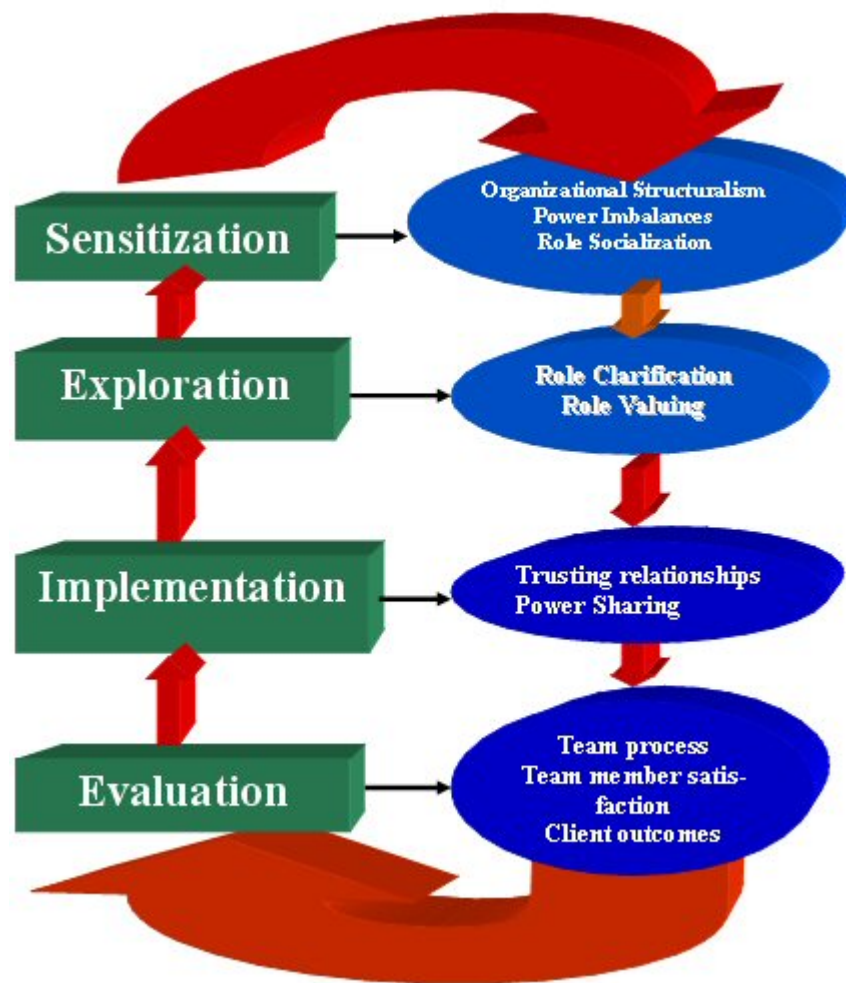


Figure 2. Change process during team development

by each member of a group and their requisite knowledge in exercising the same; *role valuing* where respect is shown for each other based on of each members knowledge and contribution to the team; *development of trusting relationships* where each member trusts the knowledge, decision-making capacity and sense of ethics of each group associate; and *power sharing* where a willingness exists to facilitate joint power sharing within the group regardless of educational or professional preparation.

tion of the value they each bring to the collaboration. For the duration of the *intervention phase* health professional collaborative teams work with their patients to gain an understanding of how both power can be shared and each member's role can be valued. In the final phase, *evaluation*, all participants assess the impact of their collaboration on patients' satisfaction with their participation. Each of the framework components will be explored more fully below commencing with the barriers and en-

ablers to IDCP and followed by the change process facilitating the creation of IDCP.

Barriers to IDCPP

Sources of conflict within interprofessional healthcare teams can be the result of: ignorance to the conceptual basis for practice of other disciplines; poor communication among members of different disciplines; chauvinistic attitudes; distrust; and lack of confidence in other disciplines.²⁶ Autonomous and specialized professional training and socialization lead many professionals to believe that their discipline is sovereign. Few professionals are knowledgeable about the scope of practice, expertise, responsibilities, and competencies of other disciplines.²⁶ At the same time, collaboration, a relationship of interdependence, requires recognition of complementary roles²⁷ and a respect for each discipline's scope of knowledge and uniqueness of functions.

Teams operate within organizations that have their own rules, procedures and expectations. As such, organizational cultures can create barriers to interdisciplinary collaborative practice. These larger systems may be less tolerant of innovative practice arrangements thus impeding creation of interdisciplinary teams. Furthermore, interdisciplinary teams seldom choose their members, and it is common for individuals to leave and new members to join. Turnover occurs because health care systems often encourage high staff turnover and rotation of health professionals.²⁸

Barriers to IDCP appear to cluster into three thematic groups: organizational structuralism power imbalances, and role socialization.

Organizational Structuralism

Organizational structuralism is defined as the administrative organization and decision-making processes adopted within an institution to achieve mandates given by authority levels. These authorities include: Acts and statutes established at federal and provincial levels of government; provincial and national regulators of health professional practice, national health accreditation agencies, judicial system, and insurance carriers. All of these authorities place requirements on how health agencies manage operations and control employees and health professionals who function within.

Organizations need to shift from their rigid bureaucratic structures to facilitate health professionals providing patient-centered care through IDCP teams. This shift will move decision-making to the level of practice where patients come to seek resolutions to their health issues. This shift needs to create a change from directing and controlling health professionals' practice to providing supportive environments with needed resources to deliver a level of care agreed to by health teams in consultation with patients. Drinka & Clark refer to this needed shift as organizational power equalization where leadership is "...unstructured, shared, informal, functional, empowering, participative, ...and ...consultat[ive]...".²⁹⁻¹⁰² In contrast the current health system has created an environment where health professionals feel their control over care has been eroded, resulting in perceived lack of organizational support.³⁰

Power Imbalances

Power according to Forbes & Fitzsimons "is a democratic concept with participation as a basic right"³¹⁻⁸. Power imbalances cluster into two broad categories: role conflict and goal conflict²⁶. The former results from "overlapping competencies and responsibilities, preconceptions that professionals have of their own role, and stereotypic perceptions that professionals hold of members of other disciplines".²⁶⁻²⁸⁸ In contrast goal conflict relates to value differences arising from "dissimilar philosophies, religious beliefs, or professional socialization...".²⁶⁻²⁸⁶ Unequal exercising of power occurs in situations, between the health professionals and others in the health system and among different groups of health professionals.³²

Although health professionals would likely report that they work in teams, in reality team members identify with their own professional group and this "blocks their ability to consider the opinions and perspectives of others".³³⁻¹⁰³ Turf wars, weak leadership, and confusion regarding levels of autonomy and authority can have negative effects on abilities of team members to work together and produce results.³⁴ The downfall to the continued delivery of health care services within the existing system is that these power imbalances can lead to conflict within and between health professionals and lead to higher health costs through energy expended from the frustration within teams and potentially leading to patient safety problems.

A further power imbalance exists between the health care system and the patient who is generally excluded from the planning for, implementation of, and evaluation of their health care.

At the same time patients' complex care requirements necessitate use of collaborative approaches by health professionals. Jimmieson & Griffin reporting on a study exploring patient satisfaction with their health care found role conflict negatively affected patient satisfaction with their care.³⁵ Consequently, power in the evolving system needs to shift to focus on achieving goals through cooperation not competition³¹ and valuing of each profession's role and competence.³⁶

Historically, the nurse-doctor relationship has been fraught with conflict²⁷ and an unequal exercise of power among health professionals within the health system is leading to barriers for IDCP. Termed 'turf issues' this imbalance is a legacy of our current system that provides a narrow gate for patients accessing the system. In Canada access is through either a family physician or more recently nurse practitioner. Physicians are also the final decision-makers in relation to patients' treatment plans. Professional isolation within a discipline is believed to result in 'turf issues'³⁷ which in turn create significant obstacles to IDCP.

Collaboration based on a relationship of interdependence, built on respect, trust and understanding of the unique and complementary perspectives of each profession cannot occur without resolution of this power imbalance. Moreover, an acceptance of patient's views must also be respected. Even though health professionals verbally support patient-centered care territorial issues regarding who should be in charge interferes.³¹ Hence, both a systemic structure, physician decision-making, and disciplinary practice isolation seem to be primary reasons for the failure of healthcare teams to commit themselves to an interdisciplinary process and relinquishing perceived independent decision-making.³⁸

Role Socialization

According to Clark the development of both an identity and pattern of practice in health professions is based on a *process of socialization* in which knowledge, skills, values, roles and attitudes associated with the particular professionals' practice are acquired³⁹. Each discipline has its unique way of thinking and acting; its own culture. Disciplinary cultures are founded on prevailing assumptions

about appropriate epistemological, behavioral and normative bases of action. Thus, each member of a health discipline brings a different set of values about teamwork based on professional socialization, personal experiences and beliefs.

Upon entering collaborative practice, health professionals must learn to accept a blurring of practice boundaries and trust other discipline members in sharing patient care processes.³² Consequently, role socialization must be expanded to include collaboration with other health professional colleagues.⁴⁰ Hence, a cultural shift in re-socializing health professionals, administrators and educators is required for IDCP to occur.²⁶ Obviously, interdisciplinary collaborative practice does not preclude strong disciplinary socialization but this is enhanced with an understanding of the complementary skills and expertise that all health professionals can bring to patient care practice.⁴⁰ Effective interdisciplinary collaboration depends upon establishing an understanding that respects differences in values and beliefs.

Enablers to IDCP

Role Clarification - This phase called role clarification is based on gaining both an understanding of all roles assumed by members of a disciplinary group and their knowledge in exercising these roles. Each health professional discipline will need to discuss and acquire: (a) a clear understanding of their own roles and expertise; (b) confidence in their own abilities; (c) recognition of boundaries of their own discipline; (d) commitment to values and ethics of their own profession; and (e) knowledge of their own disciplinary practice standards. Movement towards role clarification requires discussion around the constructs, in particular beliefs and values that underlie disciplinary boundaries of each discipline.

Role clarification also necessitates discussion around patients' participation within the health care team. Health professionals and patients initially need to explore their views towards full participation of patients as members of interdisciplinary teams⁴¹. The crux to role clarification is acceptance of a less dogmatic boundary between health disciplines. Hence, during the sensitization process it is important that all participants accept that each member of a profession has both the right and ultimate responsibility to argue about the truth and usefulness of ideas within his or her professional domain. Allowing group members to share their frustrations and challenge each other for a change in

practice fosters open dialogue that is respectful, but at the same time honest and open. It is from this base of understandings that new modes of practice can emerge. The outcome is clarification of the roles of each professional group.³²

Role Valuing - Group members are now ready to enter the role valuing stage. Role valuing is based on showing respect for one another based on the knowledge and contribution that each member brings to the group. Respect develops once all members of an IDCP team gain clear understandings of the unique contributions that each can bring to the care process. Role valuing among health professionals facilitates sharing of self, ideas, responsibility, aspirations, and disagreement. Valuing the contribution of each health professional will create a climate of openness and respect with a guarantee for safe expression of opinions and feelings without retaliation.²⁶ An outcome is trusting relationships.

Development of trusting relationships - Trust evolves when there is respect for each other's values. Values believed to be essential for collaborative teamwork are - *mutual respect, trust, and synergy*.⁴¹ Mutual respect means team members have a "commitment to values and ethics of [their] own profession, ... [recognize the] expertise of colleagues, ... and ...the interdependency of practice".⁴²⁻¹⁹⁰ Lindeke & Block describe 'level of trust' as a belief that other team members are accessible, dependable and acting with moral intent³⁴. Trust is an important element in effective collaborative practice and when it is lacking team effectiveness can be undermined. Trust not only influences commitment to group goals, but influences group attachment and support of group decision-making³⁴. Trust in a collaborative effort not only influences commitment to group goals, but influences group attachment and support of group decisions³⁴ and is prerequisite for developing collaborative cultures⁴³. Fostering trusting relationships among collaborative groups creates synergy and a tolerance of assertiveness, enhanced communication, cooperation, and shared decision-making around coordination of care.⁴⁴

Trusting relationships will be evident: (a) when there is shared responsibility for patients' care⁴⁵, (b) care is a cooperative shared venture, (c) a team approach is adopted with willing participation, shared planning and decision making, (d) contributions of expertise and shared responsibility allocated through non-hierarchical relationships, and (e) power is shared based on knowledge and expertise versus role or title.⁴⁶

Power sharing - The process of development and change²⁶ is achieved through *power sharing*. This suggests that decision-making power will need to be shared with other members of the team⁴⁷. Sharing of power is discussed further within exploration below.

Creating an IDCP Model for Practice

Thus, moving from the current care delivery models to IDCP will require a significant change in the way health professionals are educated and socialized into their roles, in how the health system operates, and in how patients participate in their care. This shift will require health professionals and patients to participate in change processes from the previously identified barriers to adopt enablers. We envision a four-stage change process starting with *sensitization* where a developing awareness about issues affecting members in different health disciplines occurs as they work across disciplines. A similar but independent process follows with health professionals' sensitization with patients who are encouraged to frankly share their issues in receiving care. This change process moves on to *exploration* which provides a means for establishing a model for collaborative working relationships across disciplines and with patients; then to *intervention* where the agreed upon model of IDCP is tested with patient groups; and finally *evaluation* when outcomes of the IDCP models are determined (Figure 2).

Sensitization - Initially the focus is on creating awareness for the need to change from current practice models. During the sensitization process the three barriers to establishing IDCP, *organizational structuralism, power imbalances, and professional socialization* discussed previously are brought forward by group members. Participants share issues they have about each other and the myths that abound relating to knowledge and skill capabilities of other disciplines. All viewpoints are respected allowing for full disclosure of issues that can interfere with collaboration. Members then assist each other in clarifying misperceptions about each other's knowledge and practice. A repeat of this process occurs with a selected group of patients. These patients also share their frustrations in interacting with various health professionals and clarify the role they wish to have in future collaborative care processes. The scene is set to move into the next phase, exploration.

Exploration - Exploration focuses on a clarification of roles and a valuing of the contributions that each team member brings to the interdisciplinary collaborative process. Members then consider where overlapping skills exist among the group. Patients then share the role they wish to have within the interdisciplinary collaborative care process. Members finally agree upon unique and collaborative contributions that each member can have in the care process. The former is termed 'role clarification' and the latter 'role valuing.'

Initially role clarification is explored within each health professional discipline by having members focus on their unique knowledge and skills and then across the health professional disciplines. Team members gain an understanding of role overlaps and begin to develop role valuing of each other, discussed previously. A next step is exploring what is the team's shared vision and norms of practice.

Once the team of health professionals has discussed the values and beliefs related to how they wish to work together, they can begin to develop their shared vision for collaborative practice. An antecedent to formulating this shared vision is establishment of what members' expectations will be from each other and clarifying what each other's beliefs are about interdisciplinary collaboration and teamwork.⁴⁸ Operating as an interdisciplinary team will require resources. When teams operate within an agency Laschinger, Almost & Tuer-Hodes suggest that managers must also be involved in shaping this collaboration.⁴⁴

Decision-making that includes: explicit definition of problems; clarification of member roles and involvement in decisions; understanding of how to determine when sufficient and relevant data about the problem is achieved; willingness to generate many options and alternatives, shared testing of various options, and a built-in commitment to act with specified responsibilities. Consensus in shared decision making need not be a unanimous decision, rather an equal opportunity for each member, including the patient, to influence the outcome.²⁶

Leadership and handling of conflicts within healthcare teams are the most critical elements to their success. Leadership should reflect "non-hierarchical relationship between the professions with an equitable distribution of work, authority, responsibility, and credit for success"⁴⁹⁻² and allow for work across health professional's disciplinary boundaries that "are open and ...remain open to the

external environment."²⁹⁻⁴⁴ Interdisciplinary teamwork leadership is not constant as "no one leader can provide all the leadership in any complex situation"²⁹⁻¹³¹. The role of leaders in IDCP models should be flexible depending on the unique patient situation. "Members who are seen as either extremely competent clinicians or as extremely creative problem solvers" are considered best in the leadership role because of their skills as process analyzers.²⁹⁻¹²⁷

Development of IDCP models requires health professional groups to consider the constructs of patient care practice. These being: "conceptualization of professional practice," "re-conceptualization of patient care," "vision of what service might be like" and "working with boundaries."³²⁻⁴²⁵

Conceptualization of professional practice is dependent on addressing: (1) power relationships and sharing among members; (2) shared values between and among collaborative relationships; (3) role clarification of each group member; and (4) development of collaborative working relationships. Interdisciplinary healthcare teams are then organized around solving a common set of problems; working together closely, meeting regularly, and communicating frequently to optimize patient care. Each member contributes his/her knowledge and skill set to augment and support the others contributions to achieve holistic management of patients' complex health problems.

Re-conceptualizing patient care delivery requires models that overcome problems raised by Gardebring. These being: (a) poor communication between disciplinary members because of use of different language sets and approaches to patient/client care; (b) duplication of services because of lack of understanding of other health professional's expertise; and (c) lack of a patient focus reflective of individualizing their distinct needs³⁷. Teams need to agree on common professional language to enhance communication.⁴⁷ The collaborative process of shared discussion with patients around care needs will, in itself, not just facilitate allocation of work to appropriate health professionals but also ensure all team members are aware of the basis of shared care planning.

A patient-centered approach to interdisciplinary care involving the patient and/or family will make it difficult for health professionals to avoid individualizing care around patients needs. At the same time bringing patients into the decision-making process

will challenge patient's socialization into the illness role. Initially health professionals may need to invite patients and their families to be active participants in the care process within their capabilities²⁹. "At the very least, patients and their families should be taught about what the team is, what to expect from it, and how the team members work together to share their expertise to improve patient outcomes."²⁹⁻¹⁸¹

Including the patient will, however, require some changes in the way health care responsibility and management is distributed. The patient will have, as a team player, to share responsibility about his/her health. The patient cannot be both the center of the new care delivery model and independent from it. The inclusion of the patient in the model will require a real balance in decision-making processes.

In IDCP each health professional discipline will need to discuss and share knowledge about: (a) their understanding of own roles and expertise; (b) confidence in their abilities; (c) recognition of discipline boundaries; (d) commitment to values and ethics of profession; (e) knowledge of disciplinary practice standards and (f) social accountability. Team members then need to achieve agreement on where disciplinary boundaries are unique and where they can be shared.

Shared decision-making has four key components: (a) assessment; (b) exploration of options; (c) selection of choices from among alternatives, and (d) implementation of the selected plan. Assessment begins with a clear definition of patients' problem(s) with adequate and relevant data²⁶, and identification of sufficient information needed to provide clarity.^{26,47} Exploration of options is carried out at two levels. First, for patients' care needs, and secondly, to determine which team member has the appropriate knowledge, skills, and abilities to deal with the patients' problem(s). In the former all parties in the team, including patients and/or relatives participate in discussions related to potential meanings for problem elements. Next meanings are translated into potential options to address each element. Hence, "...members participate only when and how they are needed."^{29-xviii} Thus, an interdisciplinary team is only utilized when complexity of patient problems necessitates more than a single health professionals expertise.²⁹

Selection of choice among alternatives involves a careful decision-making process where each op-

tion is weighed for its value in providing the means to resolve the problem coupled with willingness of the patient and/or relative to participate in planned interventions. Team members may also explore whether any other specialists should be consulted before finally selecting their care choices.^{26,47} Implementation of the plan can only proceed if all who should be consulted and informed have been prior to deciding on the plan of care.⁴⁷

Intervention - Throughout the intervention phase the developed IDCP model is operationalized and tested with patient groups. A number of authors suggest that testing IDCP models should focus on structure, process, and outcomes.^{26,40,29} Structure has been a priority within the exploration phase. Process during this intervention phase and outcomes are addressed in the next phase, evaluation. Thus, this phase focuses on team processes, an area that has not been researched in health care^{26,40}. Most of the reported research has focused on teamwork effectiveness. Hence, we do not have existing theories about the formulation and functioning of interdisciplinary healthcare teams. Research needs to explore how interdisciplinary teams operationalize their work; how they work together, and under what circumstance they form.^{29,40} Specifically, research focusing on assessing the pattern of team functioning is required.⁴⁷⁻³⁷ Patterns seem to be divided into two facets – task (how the task is accomplished) and maintenance (relates to the teams inter-group communications).⁴⁷

Productive teams focus on both tasks to be undertaken (delivery of care) and inter-group communication. Tasks needing agreements are: (a) informal leadership; (b) goal setting; (c) influencing; (d) role negotiating; (e) trust building; (f) problem solving; (g) problem setting; and (h) managing conflict.³⁸ All requiring effective inter-group communications around: (a) information about meetings; (b) other methods of communication; (c) reaction to decisions; and (d) importance of leadership.⁵⁰ A key to effective functioning is in how disagreements and conflicts are handled and specifically how to (a) accept disagreement; (b) identify issues that are likely to cause dissent; and (c) develop methods for dealing with dissent.⁵⁰ Thus, how groups problem-solve together and handle conflicts are key areas in assessing their effectiveness in task accomplishment.⁵¹ Team maintenance activities include: (a) ability of all members to use power for decision making; (b) commitment to freedom of dissent; (c) willingness to resolve conflict; (d) commitment to

evaluate and manage itself; and (e) ability to teach leadership to new members.³⁸

Evaluation - Evaluation of the IDCP model focuses on assessing team effectiveness. Four foci are considered: team process, team member satisfaction with the process, patient outcomes, and patient and/or relative satisfaction with the process and their health outcomes. Team development evolves through a change process and it is this process that is critical in establishing team effectiveness. Therefore, both a formative and summative evaluation process must be adopted to measure how interdisciplinary healthcare teams work through their evolution. Many authors suggest variables to measure team effectiveness. Variables suggested include: joint planning, shared goals, open communication, creative management of barriers⁵¹; strategies, delegation of tasks and evaluation of outcomes⁴⁷; "members' unique contributions, education backgrounds, areas of achievement and limitations;⁴⁵ evidence of task completion;⁴⁷ adequacy of resources, recognition of conflicts, conflict management skills, integrated problem solving and leader emergence.²⁹ Further suggestions are: shared goals, open communication;⁵¹ frequency of consultations (formal and informal) between team members, referrals, frequency of scheduled meetings for discussion of interdisciplinary patient management, and management of barriers.⁴⁹

Since the movement towards this new culture of care delivery has not previously been well researched, the use of qualitative approaches to gain insight into the meaning of members' changing perspectives will be a key component of evaluation.

Satisfaction with the interdisciplinary collaborative process relates to team members' and patients' perceptions of care effectiveness using this approach. Ingersoll & Schmidt suggest elements to evaluate include: effectiveness of team decision making, quality of decisions, impact of individual member commitment to decisions made by the team, member's attachment to the interdisciplinary collaborative process, and trust in the team leader⁴⁸. As with team process both quantitative and qualitative approaches can be adopted. Quantitatively, measures include: satisfaction with collaboration and care decisions^{52,53,54,55,56,57}; interprofessional team effectiveness^{58,59}; interdisciplinary team performance⁶⁰ attitudes about team work⁴⁶; perceptions of interdisciplinary relationships⁶¹; decisional conflict^{62,63} perceived organizational support,^{64,65,66,67,30} and trust and respect in workplace⁶⁸. Qualitatively,

individual or group meaning of the following areas in the team process can be explored: "(a) mutual performance monitoring, (b) back-up behaviors, (c) adaptability, (d) team leadership, and (e) team orientation."⁶⁹⁻⁸⁶⁸

Laing & Hogg report that for patients medical outcomes are the most important component of delivered services.⁵⁹ In contrast during the above evaluation it is the value patients and their relatives perceive in the "interaction between the clinical professionals and the patient that is central to the patient's evaluation of the service encounter"⁵⁹⁻¹⁸⁴ that is important. Other authors suggest that evaluation of interdisciplinary team effectiveness includes data related to cost benefits and cost effectiveness,⁷¹ improved client responses, practitioner satisfaction and efficiency in resource utilization. Without such evidence Baldwin concluded it would be difficult to move interdisciplinary collaboration into mainstream health care delivery.⁷¹ Parallel elements as outlined in the health professionals' satisfaction with interdisciplinary collaboration should be implemented with patients and their relatives. In this case the instruments used need to be complementary to those of health professionals.

Conclusion

A conceptual framework has been proposed to guide in the transition to a new culture of IDCP. IDCP involves a partnership between a team of health professionals and a patient in a participatory, collaborative and coordinated approach to share decision-making around health issues as the means to achieving improved health outcomes of patients². The culture to support interdisciplinary collaboration IDCP has to be a patient-centered collaborative practice. Barriers to this form of practice are: organizational structuralism, power relationships between health care professionals and between health care professionals and their clients, creating imbalances, and role socialization into health disciplines and society's expectations of sickness.

These factors are perceived to create a sense of disempowerment for some health professionals and clients. The power imbalance between health professionals due to professional socialization also leads to a lack of sharing in decision making around clients. Furthermore, the power imbalance between health care systems and clients frequently excludes them from planning for, implementation of, and evaluation of their health care. This leads to frustra-

tion amongst all parties who are not part of the decision-making process.

Transforming barriers into enablers can be accomplished through a change process using four phases of change: sensitization, exploration, intervention, and evaluation. Enablers include role clarification, role valuing and power sharing. Thus, during the change process power imbalances and value conflicts are challenged. It is believed that if these barriers are removed the outcome will be enhanced satisfaction with care provision by patients and care delivery by health professionals. Such satisfaction is believed to lead to empowerment of all participants in the interdisciplinary healthcare team.

Empowerment through interdisciplinary collaborative practice is believed to lead to a sharing of resources among members of the teams and a continuous desire to continue to collaborate.³³ Clearly, IDCP is a sound approach to the future of health care. Creating this type of culture among health professionals and their patients will inevitably result in heightened quality of care. IDCP is a new way of approaching 'wicked problems' in health care.²⁹ Carroll-Johnson summarizes what interdisciplinary collaboration could achieve for all...

Imagine a world where each group's expertise is held in regard, offered, and shared as the need arises. Imagine a time when the patient can determine which kinds of practitioners he or she needs or wants, and then imagine a system that makes those professionals available.⁷²⁻⁶¹⁹

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